COMMUNITY REHABILITATION & TREATMENT SERVICES (CRT)
SPECIAL SERVICES FUNDING REQUEST

Special Services Funding is requested for needs and/or services necessary and supporting the approved Individual Plan of Care (IPC) for the following **enrolled CRT client**.

Client Name (full): _____

Date of Birth _____ Social Security Number _____

Agency _____

Diagnosis: DSM-IV Code _____ Diagnosis _____

Financial Status: ❑ No benefits ❑ SSI ❑ SSDI ❑ General Assistance
❑ Medicaid ❑ Medicare ❑ Other Insurance
❑ Other (specify) _____
❑ Applied for benefits (specify) _____ When? _____

Brief description of client: _____
_____
_____
_____

Brief description of need and how it supports IPC: _____
_____
_____
_____

Describe resources already explored: _____
_____
_____

Specific Request: $_____ For _____
❑ One-time cost ❑ Ongoing need (if ongoing, how will it be funded in the future?)
_____

Has client received special funds previously? _____ If yes, when?_____

Name of person to contact with questions regarding this form: _____

Phone Number: _____

CRT Director's Name: _____
(*Type or Print*)

CRT Director's Signature: _____ Date: _____